



Department of Health
Office of Emergency Medical Services & Trauma System

RECERTIFICATION APPLICATION

<hr/> Last Name	<hr/> First Name	<hr/> M.I.
<hr/> Social Security Number <small>(Required under 42 USC 666 and Chapter 26.23 RCW)</small>	<hr/> Date of Birth <small>(mm/dd/yyyy)</small>	<hr/> Phone Number
<hr/> Address, City, State, Zip Code <small>(Where you want your certification card to be sent)</small>		
<hr/> E-mail Address		

THIS RECERTIFICATION APPLICATION IS FOR: (Please Select One)

Part 'A'

First Responder EMT IV Tech Airway Tech IV/Airway Tech ILS Tech ILS W/Airway Paramedic

Check one of the following:

- a. Recertification at your **current** certification level.
- b. Reversion to a **lower** EMS certification level.
- c. Reinstatement of an expired certification.

Are you **primarily** a "Paid" or "Volunteer" EMS provider? PAID VOLUNTEER

Are you a high school graduate or have you earned a GED certificate? YES NO

HOW HAVE YOU MET YOUR CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS FOR THE LAST CERTIFICATION PERIOD?

Part 'B'

Please check one: Traditional CME* **OR** OTEP
* Requires state certification exam

1. ILS AND ALS LEVELS ONLY - Have you successfully completed the Skills Maintenance requirements for your level of certification? YES NO

EMS AGENCY ASSOCIATION REQUIREMENT:
YOUR LICENSED EMS AGENCY:

Part 'C'

Name: _____

Address: _____

Phone Number: _____

EMS Contact Person: _____

Agency License Number: _____

FOR DOH OFFICE USE ONLY: Part D ____ Exam ____ OTEP ____

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RECERTIFICATION APPLICATION - CONTINUED

Part 'C'

If you are recertified, will you continue to provide EMS care with the agency you identified on the front of your application?

YES

NO

(continued)

EMS AGENCY SUPERVISOR:

"I affirm that if this applicant is recertified, he/she will provide care with our EMS agency".

Name of EMS Agency Supervisor

(Please Print)

Original Signature

Date

MEDICAL PROGRAM DIRECTOR:

The signature of the Washington State Medical Program Director (MPD) for the county where the applicant is providing care, or where his/her EMS agency is based, is *required* before state certification may be granted to this applicant.

"I recommend certification

I do not recommend certification (attach a memo for details)

of this applicant based on the statements above, pending successful completion of the required examinations and/or evaluations. This applicant, if recommended for recertification, has a copy of my county protocols".

MPD's Original Signature

Date

APPLICANT:

"I hereby affirm and declare that the information provided on this application is *true* and *correct*, and that any fraudulent entry may be considered sufficient cause for *rejection* or subsequent *revocation* of my certification. I further affirm that I have received a copy of my MPD's *protocols* for my level of certification".

Applicant's Original Signature

Date

NOTE: Pages 1 and 2 of this application is good for a period of one year from date the applicant signs the form.

RETURN COMPLETED APPLICATIONS TO:

Office of Emergency Medical Services & Trauma System
Licensing and Certification Section
PO Box 47853
Olympia, WA 98504-7853

1-800-458-5281, Ext. #1 or (360) 236-2845

Office of Emergency Medical Services and Trauma System website: www.doh.wa.gov/hsqa/emtp/

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RECERTIFICATION APPLICATION

Office of Emergency Medical Services and Trauma System

Part 'D' - Personal Information

C O N F I D E N T I A L

Certification of health care professionals is designed to protect the citizens of Washington State from unsafe health care. As part of the certification process, all applicants for certification are required to answer the same, legally defensible, personal data questions, narrowly focused to the fitness to practice the essential skills of this profession.

Part 'D' must be completed by all applicants and returned *directly* to the Department of Health to maintain confidentiality. Please follow the instructions below:

1. Detach, review and complete this portion of the application. Make sure you provide *accurate* information.
2. Attach additional information (if appropriate), and mail it to the address shown on the bottom of Page 4.

LAST NAME

FIRST NAME

M.I.

ADDRESS, CITY, STATE, ZIP CODE

SOCIAL SECURITY NUMBER

(Required under 42 USC 666 and Chapter 26.23 RCW)

COUNTY OF PRIMARY EMPLOYMENT

Yes No

1. Do you **currently** have a medical condition which **in any way impairs or limits your ability to provide EMS with reasonable skill and safety**? If "yes", please explain.

☐ ☐

"**Currently**" means recently enough so that your medical condition may have an ongoing impact on your ability to function as an EMS provider, and includes at least the past two years.

"**Medical condition**" includes physiological, mental or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question #1, please explain if, and how, the limitations or impairments caused by your medical condition are *reduced* or *eliminated* because you receive ongoing treatment. (Are you using medication to treat this condition? If so, please list).

1b. If you answered "yes" to question #1, please explain if, and how, the limitations or impairments caused by your medical condition are *reduced* or *eliminated* because of your field of practice, the setting, or the manner in which you have chosen to practice.

If you answered "yes" to question #1, the Department will make an assessment of the nature, severity, and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" to determine if you are eligible for certification and whether conditions should be imposed.

2. Do you **currently** use chemical substance(s) in any way which impairs or limits your ability to provide EMS with reasonable skill and safety? If "yes", please explain.

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"**Currently**" means recently enough so that the use of chemical substance(s) may have an ongoing impact on one's functioning as a certified EMS provider, and includes at least the past two years.

"**Chemical substances**" includes alcohol, drugs or medications, in addition to those taken by way of a valid prescription for legitimate medical purposes in accordance with the prescriber's direction.

3. Are you **currently** engaged in the *illegal* use of controlled substances?

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"**Currently**" means recently enough so that the use of controlled substances may have an ongoing impact on your ability to function as a certified EMS provider, and includes at least the past two years.

"**Illegal use of controlled substances**" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances not taken in accordance with the directions of a licensed healthcare practitioner.

RECERTIFICATION APPLICATION (continued)

Yes No

4. Have you ever been diagnosed as having, or have you ever been treated for: Pedophilia, exhibitionism, voyeurism or frotteurism?

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"Pedophilia" means: An unnatural desire for sexual relations with children.

"Exhibitionism" means: An abnormal impulse that causes one to expose the genitals to one of the opposite sex.

"Frotteurism" means: Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a non-consenting person.

"Voyeurism" means: Deriving sexual pleasure from observing the sexual activity of others.

If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, no contest (nolo contendere) or a plea of similar effect, or had prosecution or sentence deferred or suspended in connection with:

a. The use or distribution of controlled substances or legend drugs?

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b. A charge of a sex offense?

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c. Any other crime other than *minor* traffic infractions? (For example: Driving While Intoxicated (DWI), Driving Under the Influence (DUI), and Reckless Driving).

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6. Have you ever been found in any civil, administrative, or criminal proceeding to have:

a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?

☐ ☐

b. Committed any act involving moral turpitude, dishonesty or corruption?

☐ ☐

c. Violated any state or federal law or rule regarding the practice of a health care profession? If "yes", explain and provide copies of all judgments.

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7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions and agreements.

☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended or restricted by a state, federal or foreign authority? Have you ever surrendered such credential to avoid, or in connection with, an action by such authority?

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9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?

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10. Have you previously provided the Department of Health with information regarding any "yes" answers?

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PLEASE NOTE: If you have answered "yes" to any of the above questions, you must submit a brief written statement and all relevant documents with this portion of the application. Please do not *re-send* documents which you have previously provided to this office to explain any "yes" answers.

APPLICANT STATEMENT: (This portion must be signed by the applicant)

"I hereby affirm and declare that the above information is true and correct, and that any fraudulent entry may be considered sufficient cause for rejection or subsequent revocation of my certification."

Applicant's original signature only

Date

Phone #

NOTE: Part D, pages 3 and 4 of this application is good for a period of 6 months from date the applicant signs the form.

Department of Health, Office of Emergency Medical Services & Trauma System, P.O. Box 47853, Olympia WA 98504-7853